Recipient Change Report Form

(Form 295 Instructions, 03/2009)

Purpose: For the Medicaid recipient to report changes.

Distribution: Original – Case file.

Instructions:

1. Enter Name of recipient making change.
2. Enter Medicaid number.
3. Enter address.
4. Enter home phone.
5. Enter other phone.
6. Enter city, county, state and zip.
7. Check if the address is new. If yes, fill in date moved.
8. Check all applicable areas that apply to the change (marital status, family, income, day/night care expenses, insurance, death, closing their Medicaid case, withdrawing their Medicaid application or other changes).
9. Recipient is to check box to declare that the information entered is true and correct.
10. Recipient signs form.
11. Enter date form is signed.
12. If someone else helps to fill out form, they sign here.
13. Enter a phone number for person helping to fill out form.
14. Person helping to fill out the form checks if they are an Application Assister or not.

Alabama Medicaid Agency's Recipient Change Report Form

Name_____**(1)**_____ Medicaid #_____**(2)**_____

Address_____**(3)**_____ Home Phone_____**(4)**_____

City/County/State/Zip_____**(5)**_____ Other Phone_____**(6)**_____

Is this a new address? ☐ Yes ☐ No If Yes, Date Moved_____**(7)**_____

Check the items that you have changes for. (There are more items listed on the back of this form.) NOTE: Your signature is required on the back of this form.
(8)

☐ **Marital Status Changes**. Date of change_____

New marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

If you checked Married, please complete the following:

Name of Spouse_____

Spouse's SSN_____ Spouse's DOB_____

Spouse's Address_____

City, State, Zip_____ Phone_____

☐ **Sponsor Address and Phone Changes**. Date of change _____

New Sponsor Address_____

City, State, Zip_____ Phone_____

NOTE: To change your sponsor to another person, you will need to complete a Form 202 and mail to your caseworker or call 1-800-362-1504 to request a Form 202 be mailed to you.

☐ **Family Changes.** Date of change _____

☐ **I Had a Baby.** Baby's Name is_____ ☐ Male ☐ Female

Baby's SSN_____

Baby was Born on_____(date) in _____(city/state/zip)

☐ **Someone in My Household is Having a Baby.** Her Name is_____

Date Baby is Due_____ Number of Babies in Pregnancy_____

☐ **Person(s) Moved Into My Home.** Date of change _____

Name	Relationship to You	Income	Date of Birth	SSN	Receiving SSI, Yes/No

☐ **Person(s) Moved Out of My Home.** Date of change _____

Name	Relationship to You	Income	Date of Birth	SSN

☐ **Income Changes**. Date of change _____

☐ **New Income.**

Name	Employer Name and Address	Gross Amount of Pay (before deductions)	Hourly Pay Rate	Hours Worked a Week	How Often Paid	Day Paid

(Attach verification of income.)

☐ **Loss of Income.** Person Who No Longer Has Income is_____
Date of Last Pay Received_____.

☐ **Expense changes.** Date of change _____

☐ **I Now Pay for Day/Night Care.**
Name of Person Who Pays_____
Name and Age of Person(s) in Care_____
Amount Paid_____ How Often_____

☐ **I No Longer Pay for Day/Night Care**.

☐ **Insurance Changes**. Complete the "Report Insurance Coverage Change Form" which is located on the Medicaid Website at www.medicaid.alabama.gov.

☐ **Report of Death**.
Name of Recipient_____ Date of death_____

☐ **I wish to close my Medicaid case.** Date _____
Reason for closing case _____

☐ **I wish to withdraw my application**. Date _____

☐ **Other Changes**. Date of change_____
Explain_____
_____

(9)

☐ By checking this box, I declare under penalty of perjury, that the information I have entered is true and correct.

(10)_____ **(11)**_____
Signature of Recipient Date

(12)_____ _____**(13)**_____
Person Helping to Fill Out Form Daytime Phone Number

(14) I am an Application Assister ☐ Yes ☐ No

You may Fax this form to 334-353-5689, or Mail to: Alabama Medicaid Agency, Attn: Eligibility Change Unit, 501 Dexter Avenue, P O Box 5624, Montgomery, AL 36103-5624.